Pediatric History Questionnaire

Patient Information

Chart # _____ Date _____

Patient Name _____
First Last MI

Age _____ DOB _____ ☐ Male ☐ Female Phone _____ Cell _____

Address _____ City _____ State _____ Zip _____

Parents Full Name _____ Reason for Appointment _____

E-Mail _____ E-Statements Yes No

Enrolled in First Steps? ☐ Yes ☐ No If yes, Service Coordinator: _____ County

Primary Care Physician _____ Phone

Medical History

Did your child have an infection at birth?

○ None ○ Cytomegalovirus ○ Rubella ○ Herpes ○ Syphilis ○ Toxoplasmosis

Did your child have asphyxia or breathing problems at birth? ○ Yes ○ No

Were any blood transfusions given? ○ Yes ○ No

Please describe _____

Was your baby in an Intensive Care Unit? ○ Yes ○ No

Were there any congenital malformations involving the head, neck or ears? ○ Yes ○ No

What was your baby's weight? _____

Was your baby born prematurely? ○ Yes ○ No How many weeks? _____

Was your baby treated with any antibiotics? ○ Yes ○ No If so, what kind? _____

Did your baby ever have Meningitis? ○ Yes ○ No If so, at what age? _____

Did your baby have elevated bilirubin (jaundice)? ○ Yes ○ No

Is there family history of hearing problems in early childhood? ○ Yes ○ No

○ Mother ○ Father ○ Grandmother ○ Grandfather ○ Brother

○ Sister ○ Uncle ○ Aunt ○ Cousin ○ Other

Does your child have any other associated disability? ○ Yes ○ No

○ Blindness or vision disorder ○ Cerebral Palsy ○ Developmental disability

○ Seizure disorder ○ Down Syndrome ○ Learning disability

○ Other _____

When did you last consult a physician about your child's ears? _____

Has your child had any earaches? ○ Yes ○ No If so, which ear(s)? ○ Left ○ Right ○ Both

Have their ears been medically treated? ○ Yes ○ No If so, which ear(s)? ○ Left ○ Right ○ Both

Is your child receiving any medication? ○ Yes ○ No If so, what kind? _____

Has your child ever had ear tubes? ○ Yes ○ No If so, when? _____ By whom? _____

Has your child experienced dizziness? ○ Yes ○ No If so, which ear(s)? ○ Left ○ Right ○ Both

Pediatric History Questionnaire

Hearing and Speech History

Do you think your child has a hearing problem? ○ Yes ○ No

How old were they when you first noticed a hearing loss? _____

Has your child's hearing been tested before? ○ Yes ○ No

Does your newborn startle at loud sounds? ○ Yes ○ No ○ N/A

Does your three-month-old stop moving or crying when you call them? ○ Yes ○ No ○ N/A

Does your six-month-old enjoy noise-making toys? ○ Yes ○ No ○ N/A

Does your nine-month-old babble frequently? ○ Yes ○ No ○ N/A

Does your one-year-old respond to simple yes or no commands? ○ Yes ○ No ○ N/A

At what age did your child first babble? _____ First word _____

Short (2–3 word) sentences _____

How many words does your child have in his/her vocabulary? _____

How often does your child use speech? ○ Frequently ○ Occasionally ○ Seldom ○ Never

Is your child's speech clear? ○ Yes ○ No ○ N/A

If school aged, where does your child attend school? _____

Do you have any concerns about your child's progress in school? ○ Yes ○ No

If so, please explain _____

How did you hear about our services?

○ Doctoral referral ○ Advertisement ○ School

○ Friend ○ Yellow pages ○ Previous patient

○ Other _____

Is there any other information about your child that is important for us to know? _____

_____

Authorization for Release of Information

I authorize Doctors Hearing Care to release any part or all of my records to those persons listed below:

	Name	Address
1.	_____	_____
2.	_____	_____
3.	_____	_____

Signature _____ Date _____

Print Name _____

Relationship to Patient _____

Your Experience

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	☐ Excellent	☐ Average	☐ Poor
Adequate parking	☐ Excellent	☐ Average	☐ Poor
Convenience of appointment times	☐ Excellent	☐ Average	☐ Poor
Friendly greeting	☐ Excellent	☐ Average	☐ Poor
Clean and welcoming environment	☐ Excellent	☐ Average	☐ Poor

What can we do to make your next visit more comfortable?

_____

_____

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

*************PLEASE READ CAREFULLY AND SIGN BELOW*************

- I give permission to my AudigyCertified™ practice to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

REFUSE TO RELEASE RECORDS, IF SO INITIAL HERE _____

I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified practice permission to treat my concerns.

I have read and understand all the above information.

_____ _____

A copy of this signature is as valid as the original — Date

PLEASE SIGN HERE Parent or Guardian _____ Date _____